Now that you've enrolled in a Medicare Part D plan, the Centers for Medicare & Medicaid Services (CMS) requires that Express Scripts Medicare send you certain plan materials. This *Evidence of Coverage* includes information on standard rules and processes for a Medicare Part D prescription drug plan program. However, there may be situations where the plan rules as outlined here differ from Teachers' Retirement System of the State of Kentucky's plan rules and coverage. Please be sure to review your other plan materials for plan-specific information or contact Express Scripts Medicare Customer Service.

January 1 – December 31, 2017

Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of Express Scripts Medicare (PDP)

This document provides the details about your Medicare prescription drug coverage from January 1 – December 31, 2017. It explains how to get coverage for the prescription drugs you need.

This is an important legal document. Please keep it in a safe place.

This plan, **Express Scripts Medicare**® (PDP), is offered by Medco Containment Life Insurance Company or Medco Containment Insurance Company of New York (for employer plans domiciled in New York). (When this *Evidence of Coverage* says "we," "us" or "our," it means Medco Containment Life Insurance Company or Medco Containment Insurance Company of New York (for employer plans domiciled in New York). When it says "plan" or "our plan," it means Express Scripts Medicare.)

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

Express Scripts Medicare **Customer Service:**
For more help or information, please call Express Scripts Medicare Customer Service at the number on the back of your member ID card (TTY users call: **1.800.716.3231**) or go to our plan website at **http://www.Express-Scripts.com**. Calls to Customer Service are free. Customer Service is available 24 hours a day, 7 days a week. Customer Service has free language interpreter services available for non-English speakers.

This information is available in braille. Please contact Customer Service at the numbers above if you need plan information in another format.

This information is available for free in other languages. Please contact Customer Service at the numbers on the back of your member ID card for additional information. Customer Service is available 24 hours a day, 7 days a week. Esta información está disponible sin cargo en otros idiomas. Comuníquese con el Servicio de atención al cliente de Express Scripts Medicare llamando a los números que figuran al dorso de su tarjeta de identificación de miembro para obtener información adicional. El Servicio de atención al cliente está disponible las 24 horas, los 7 días de la semana.

Benefits, premium and/or copayments/coinsurance may change on January 1 of each year. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary. Limitations, copayments and restrictions may apply. E00KTA7A

2017 Evidence of Coverage

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Chapter 1. Getting started as a member of Express Scripts Medicare

SECTION 1 Introduction

Section 1.1 You are enrolled in Express Scripts Medicare, which is a Medicare prescription drug plan

Teachers' Retirement System of the State of Kentucky (TRS) has chosen to provide your Medicare Part D prescription drug coverage through our plan, Express Scripts Medicare.

There are different types of Medicare plans. Express Scripts Medicare is a Medicare prescription drug plan (PDP). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company.

Section 1.2 What is the *Evidence of Coverage* about?

This *Evidence of Coverage* tells you how to get your Medicare prescription drug coverage through our plan. It explains your rights and responsibilities and what is covered.

The words "coverage" and "covered drugs" refer to the prescription drug coverage available to you as a member of Express Scripts Medicare.

It's important for you to learn what the plan's rules are and what coverage is available to you. We encourage you to set aside some time to look through this *Evidence of Coverage*.

If you are confused or concerned or just have a question, please contact Express Scripts Medicare Customer Service (contact information is listed on the back of your member ID card).

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how Express Scripts Medicare covers your care. Other parts of this contract include your eligibility record, the 2017 *Formulary (List of Covered Drugs),* your *Benefit Overview,* your *Annual Notice of Changes* packet and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in Express Scripts Medicare between January 1, 2017, and December 31, 2017.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Express Scripts Medicare after December 31, 2017. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2017.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services, or CMS) must approve Express Scripts Medicare each year. You can continue to get Medicare coverage as a member of our plan only as long as your former employer or your retiree group chooses to continue to offer the plan for the year in question and CMS renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You live in our geographic service area (**Section 2.3** below describes our service area)
- You are entitled to Medicare Part A and/or enrolled in Medicare Part B (**Section 2.2** tells you about Medicare Part A and Medicare Part B)
- You are a United States citizen or are lawfully present in the United States.
- You qualify for coverage from TRS

Section 2.2 What are Medicare Part A and Medicare Part B?

Because you meet the requirements noted above in the previous section, you will receive prescription drug coverage (sometimes called Medicare Part D) through this plan. Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract. This document and other plan materials you have received, such as the *Benefit Overview* or *Annual Notice of Changes*, describe that coverage.

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by institutional providers such as hospitals (for inpatient services), skilled nursing facilities or home health agencies.
- Medicare Part B is for most other medical services (such as physicians' services and other outpatient services) and certain items (such as durable medical equipment and supplies).

Section 2.3 Here is the plan service area for Express Scripts Medicare

Although Medicare is a Federal program, Express Scripts Medicare is available only to individuals who qualify for coverage from their former employer or retiree group and live in our plan service area. To stay a member of our plan, you must keep living in this service area. Our service area includes all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa.

If you plan to move, please contact TRS.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers for Social Security in **Chapter 2, Section 5.**

Section 2.4 U.S. Citizen or Lawful Presence

A member of a Medicare prescription drug plan must be a U.S. citizen or lawfully present in the United States. Medicare will notify Express Scripts Medicare if you are not eligible to remain a member on this basis. Express Scripts Medicare must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your member ID card – Use it to get all covered prescription drugs

While you are a member of our plan, you must use your member ID card for our plan for prescription drugs you get at network pharmacies. Below is a sample member ID card to show you what yours may look like. **If you are an existing member, your card may look slightly different.**

Please carry your card with you at all times and remember to show your card when you get covered drugs. If your member ID card is damaged, lost or stolen, call Customer Service right away and we will send you a new card. (Phone numbers for Customer Service are listed on the back of your member ID card.)

You may need to use your red, white and blue Medicare card to get covered medical care and services under Original Medicare.

Section 3.2 The *Pharmacy Directory:* Your guide to pharmacies in our network

How do you find participating network pharmacies?

Our *Pharmacy Directory* gives you a list of the retail network pharmacies closest to you — that means the pharmacies in your area that have agreed to fill covered prescriptions for our plan members — as well as other pharmacies (such as long-term care (LTC) pharmacies) in our network.

Why do you need to know about network pharmacies?

With few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them. There may be changes to our network of pharmacies for 2017.

If you don't have a *Pharmacy Directory,* you can get a copy from Customer Service (phone numbers are listed on the back of your member ID card). At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at **http://www.Express-Scripts.com**. If you have not already registered on our website, we encourage you to do so. The information you will need to complete registration can be found on your member ID card. It will also be helpful to have a recent prescription handy.

Section 3.3 The plan's 2017 *Formulary (List of Covered Drugs)*

The plan has a *Formulary (List of Covered Drugs)* for the 2017 plan year, which we will send to you. We call it the "Drug List" for short. It tells which commonly used Part D prescription drugs are covered by Express Scripts Medicare.

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The Express Scripts Medicare Drug List meets the requirements set by Medicare and has been approved.

The Drug List also tells you if there are any rules that restrict coverage for covered drugs, and it includes information for the covered drugs that are most commonly used by our members. However, we cover additional Part D drugs that are not included in the printed Drug List. If one of your Part D drugs is not on the Drug List, you should contact Customer Service to find out if we cover it. To get the most complete and current information about which drugs are covered, call Customer Service (phone numbers are listed on the back of your member ID card).

Section 3.4 The Part D *Explanation of Benefits* (the "Part D EOB"): A summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary to help you understand and keep track of payments for your Part D prescription drugs. This summary is called the Part D *Explanation of Benefits* (or the Part D EOB).

The Part D EOB tells you the total amount of what you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. **Chapter 4** gives more information about the Part D EOB and how it can help you keep track of your drug coverage.

A Part D EOB summary is also available upon request. To get a copy, please contact Customer Service. In addition to receiving your Part D EOB in the mail, you may view a copy by visiting our website, **http://www.Express-Scripts.com**.

SECTION 4 Your monthly premium for Express Scripts Medicare

Section 4.1 Your plan premium

Your coverage is provided through a contract with Teachers' Retirement System of the State of Kentucky (TRS). TRS determines how your plan premium is paid. If you have questions about your plan premium, please contact TRS at 1.800.618.1687 from 8:00 a.m. to 5:00 p.m., Eastern Time, Monday through Friday, for more information.

TRS *may* charge you a plan premium or a portion of the plan premium. You are required to pay the premium according to their instructions.

If TRS does not receive your plan premium when it is due, a notice will be sent to you telling you that plan membership will end if they do not receive your plan premium within the grace period determined by TRS.

If your membership is ended due to nonpayment of premiums, you will have coverage under Original Medicare. At the time your membership is ended, premiums that have not been paid may still be owed to TRS. If this occurs and you want to enroll again in our plan, contact TRS. Any past-due premiums may need to be paid before they can re-enroll you.

If you think your membership has been wrongfully ended, please contact TRS to determine what steps you need to follow to have your coverage reinstated. **Chapter 7, Section 7** tells how to make a complaint. In addition, you must continue to pay any applicable Medicare Part B and Part D premiums (unless your Part B premium is paid for you by Medicaid or another third party).

In some situations, your plan premium could be less
There are programs to help people with limited resources pay for their drugs. These include the Extra Help and State Pharmaceutical Assistance Programs. **Chapter 4** tells more about these programs. If you qualify, enrolling in one or both of these programs might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, **some of the information in your other plan documents may not apply to you.** We will send you a notice called "Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs" (Low Income Subsidy (LIS) Rider), which tells you about your drug coverage. If you don't have this notice, please call Customer Service and ask for the LIS Rider. Phone numbers for Customer Service are listed on the back of your member ID card.

In some situations, your plan premium could be more
In some situations, your plan premium could be more than the amount charged by TRS. These situations are described below.

- Some members are required to pay a **late enrollment penalty (LEP)** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) For these members, the LEP is added to the plan's monthly premium.
    - If you are required to pay the LEP, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. **Chapter 4, Section 9** explains the LEP.
    - If you have an LEP and do not pay it, you could be disenrolled from the plan.

Many members are required to pay other Medicare premiums
In addition to paying your monthly Part D plan premium, some members may be required to pay other Medicare premiums. Some plan members may pay a premium for Medicare Part A and some plan members may pay a premium for Medicare Part B, in addition to paying the monthly Part D plan premium. You must continue to pay your Medicare Part B premium and Part D high-income premium to Social Security to be enrolled in the TRS Medicare Eligible Health Plan (MEHP).

Some people pay an extra amount to Social Security for Part D because of their yearly income. This is known as the Part D Income-Related Monthly Adjustment Amount, also known as Part D–IRMAA. If your income is greater than $85,000 for an individual (or married individuals filing separately) or greater than $170,000 for married couples, you must pay an extra amount directly to the government (not your Medicare plan) for your Medicare Part D coverage.

- **If you are required to pay the extra amount and you do not pay it, you <u>will</u> be disenrolled from the plan and you will lose your prescription drug coverage.**
- If you have to pay an extra amount, Social Security, **not your Medicare plan,** will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to **Chapter 4, Section 10.** You can also visit http://www.medicare.gov on the web or call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048. Or you may call Social Security at 1.800.772.1213. TTY users should call 1.800.325.0778.

Your copy of *Medicare & You* 2017 gives information about the Medicare premiums in the section called "2017 Medicare Costs." This explains how the Part D premium differs for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You* 2017 from

the Medicare website (http://www.medicare.gov). Or you can order a printed copy by phone at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

Section 4.2 Can TRS change your monthly plan premium during the year?

No. TRS is not allowed to change the amount it charges for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, you will be notified of the change in the fall and the change will take effect on January 1.

However, in some cases, the part of the premium that you have to pay can change during the year. This happens if you become eligible for, or lose your eligibility for, the Extra Help program during the year. If a member qualifies for Extra Help with his or her prescription drug costs, the Extra Help program will pay all or part of the member's monthly plan premium. A member who loses his or her eligibility during the year will need to start paying his or her full monthly premium. You can find out more about the Extra Help program in **Chapter 4, Section 11.**

SECTION 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

Your membership record has information from your eligibility record, including your address and telephone number. It shows your specific plan coverage.

The pharmacists in the plan's network need to have correct information about you. **These network providers use your membership record to know what drugs are covered and the cost-sharing amounts for you.** Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address or your phone number
- Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes

If any of this information changes, please let us know by calling either TRS or Customer Service (phone numbers are listed on the back of your member ID card). Please submit address changes in writing to TRS at 479 Versailles Road, Frankfort, KY 40601 or send a fax to 1.502.573.0199.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers for Social Security in **Chapter 2.**

Read over the information we send you about any other insurance coverage you have

That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see **Section 7** in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct and complete, you don't need to do anything. If the information is incorrect or incomplete, or if you have other coverage that is not listed, please

call the number noted in the letter you receive to provide us with the correct information to coordinate your benefits. If you have questions about pays first, or you need to update your other insurance information, call Medicare's Benefits Coordination & Recovery Center (BRCR) toll free at 1.855.798.2627, Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern Time. TTY users should call 1.855.797.2627.

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to **Chapter 6, Section 1.4.**

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage in addition to this plan), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or retiree group health plan coverage (other coverage outside of this plan):

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer and whether you have Medicare based on age, disability or End-Stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you or your family member is still working, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
    - If you're over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Service (phone numbers are listed on the back of your member ID card). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Chapter 2. Important phone numbers and resources

SECTION 1 Express Scripts Medicare contacts
(how to contact us, including how to reach Express Scripts Medicare Customer Service at the plan)

How to contact Express Scripts Medicare Customer Service

For assistance with claims, billing or member ID card questions, please call or write to Express Scripts Medicare Customer Service. We will be happy to help you.

Method	Customer Service – Contact Information
CALL	The phone numbers for Express Scripts Medicare Customer Service are listed on the back of your member ID card.
WRITE	Express Scripts Medicare P.O. Box 14570 Lexington, KY 40512
WEBSITE	**http://www.Express-Scripts.com**

How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs. For more information on asking for coverage decisions about your Part D prescription drugs, see **Chapter 7.**

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see **Chapter 7.** You may call us if you have questions about our coverage decision and appeals processes.

There are two types of coverage decisions and appeals: administrative and clinical. An administrative coverage decision or appeal occurs when the issue involves a decision about whether a medication is covered or not and at what *cost sharing* amount. A clinical coverage decision or appeal occurs when the issue involves a decision about a restriction on a specific medication.

Method	Initial Clinical Coverage Reviews (Including Prior Authorization Requests) for Part D Prescription Drugs – Contact Information
CALL	**1.844.374.7377 (1.844.ESI.PDPS)** Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.
TTY	**1.800.716.3231** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.
FAX	**1.877.328.9799**
WRITE	Express Scripts Attn: Medicare Reviews P.O. Box 66571 St. Louis, MO 63166-6571
WEBSITE	**http://www.Express-Scripts.com**
Method	**Clinical Appeals for Part D Prescription Drugs – Contact Information**
CALL	**1.844.374.7377 (1.844.ESI.PDPS)** Calls to this number are free. Our business hours are Monday through Friday, 8:00 a.m. to 8:00 p.m., Central Time.
TTY	**1.800.716.3231** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours are Monday through Friday, 8:00 a.m. to 8:00 p.m., Central Time.
FAX	**1.877.852.4070**
WRITE	Express Scripts Attn: Medicare Clinical Appeals P.O. Box 66588 St. Louis, MO 63166-6588
WEBSITE	**http://www.Express-Scripts.com**
Method	**Administrative Coverage Reviews and Appeals for Part D Prescription Drugs – Contact Information**
CALL	**1.800.413.1328** Calls to this number are free. Our business hours are Monday through Friday, 8:00 a.m. to 6:00 p.m., Central Time.
TTY	**1.800.716.3231** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours are Monday through Friday, 8:00 a.m. to 6:00 p.m., Central Time.
FAX	**1.877.328.9660**
WRITE	Express Scripts Attn: Medicare Administrative Appeals P.O. Box 66587 St. Louis, MO 63166-6587
WEBSITE	**http://www.Express-Scripts.com**

How to contact us when you are making a complaint about the quality of care you have received, waiting times, customer service or other concerns

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the previous section about making an appeal.) For more information on making a complaint, see **Chapter 7.**

Method	Express Scripts Contact Information for Filing a Complaint
CALL	The phone numbers for Express Scripts Medicare Customer Service are listed on the back of your member ID card.
TTY	**1.800.716.3231** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.
FAX	**1.614.907.8547**
WRITE	Express Scripts Medicare Attn: Grievance Resolution Team P.O. Box 3610 Dublin, OH 43016-0307
MEDICARE WEBSITE	You can submit a complaint about Express Scripts Medicare directly to Medicare. To submit an online complaint to Medicare go to http://www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for our share of the cost of a drug you have received

The coverage determination process includes determining requests that ask us to pay for our share of the costs of a drug that you have received. For more information on situations in which you may need to ask the plan for reimbursement or to pay a bill you have received from a provider, see **Chapter 5.**

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See **Chapter 7** for more information.

Method	Express Scripts Contact Information for Payment Requests
CALL	The phone numbers for Express Scripts Medicare Customer Service are listed on the back of your member ID card.
FAX	**1.608.741.5483**
WRITE	Express Scripts Attn: Medicare Part D P.O. Box 14718 Lexington, KY 40512-4718
WEBSITE	**http://www.Express-Scripts.com**

SECTION 2 Medicare
(how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities and people with End-Stage Renal Disease, also called ESRD (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare prescription drug plans, including our plan.

Method	Medicare – Contact Information
CALL	1.800.MEDICARE, or 1.800.633.4227 Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1.877.486.2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	http://www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about Express Scripts Medicare: • **Tell Medicare about your complaint:** You can submit a complaint about Express Scripts Medicare directly to Medicare. To submit a complaint to Medicare, go to http://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out and send it to you. (You can call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.)

SECTION 3 State Health Insurance Assistance Program
(free help, information and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Please refer to the SHIP listing located in the **Appendix** to find information about the SHIP in your state.

A SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment and help you straighten out problems with your Medicare bills. SHIP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

SECTION 4 Quality Improvement Organizations
(paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization (QIO) for serving Medicare beneficiaries in each state. Please refer to the QIO listing located in the **Appendix** to find information about the QIO in your state.

The QIO has a group of doctors and other healthcare professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. The QIO is an independent organization. It is not connected with our plan.

You should contact the QIO if you have a complaint about the quality of care you have received. For example, you can contact the QIO if you were given the wrong medication or if you were given medications that interact in a negative way.

SECTION 5 Social Security

The Social Security Administration (SSA) is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or End-Stage Renal Disease (ESRD) and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you have questions after receiving a letter from Social Security telling you that you have to pay the extra amount, or if your income went down because of a life-changing event, you can call Social Security to ask for a reconsideration. If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security Administration – Contact Information
CALL	1.800.772.1213 Calls to this number are free. The SSA is available from 7:00 a.m. to 7:00 p.m., Eastern Time, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day, 7 days a week.
TTY	1.800.325.0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. The SSA is available from 7:00 a.m. to 7:00 p.m., Eastern Time, Monday through Friday.
WEBSITE	http://www.ssa.gov

SECTION 6 Medicaid
(a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums and other cost sharing (like deductibles, coinsurance and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact the Medicaid agency in your state (contact information is located in the **Appendix**).

Chapter 3. Using the plan's coverage for your Part D prescription drugs

? **Did you know there are programs to help people pay for their drugs?**

There are programs to help people with limited resources pay for their drugs. These include Extra Help and State Pharmaceutical Assistance Programs (SPAPs). For more information, see **Chapter 4, Section 11.**

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** Please review the notice entitled "Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs" (Low Income Subsidy (LIS) Rider), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the LIS Rider. Phone numbers for Customer Service are listed on the back of your member ID card.

SECTION 1 Introduction

Section 1.1 This chapter explains rules for using this plan's coverage of Part D drugs

Your Part D prescription drugs are covered under our plan. In addition, Original Medicare (Medicare Part A and Part B) also covers some drugs:

- Medicare Part A covers drugs you are given during Medicare-covered stays in the hospital or in a skilled nursing facility.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit and drugs you are given at a dialysis facility.

(To find out more about coverage through Original Medicare, see your *Medicare & You* handbook.)

Section 1.2 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- You generally must use a network pharmacy to fill your prescription. (See **Section 2** of this chapter for more information.)
- Your drug is an approved Part D drug.
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration (FDA) or supported by certain reference books. (See **Section 3** of this chapter for more information.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's home delivery service

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See **Section 2.5** for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's Drug List.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?
To find a network pharmacy, visit our website at **http://www.Express-Scripts.com** or call Customer Service (phone numbers are listed on the back of your member ID card). You can also look in your *Pharmacy Directory.* If you don't have a copy of the *Pharmacy Directory* and you would like one, please call Customer Service. Choose whatever is easiest for you.

You may go to any of our network pharmacies. If you switch from one network pharmacy to another and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a doctor or to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?
If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Customer Service (phone numbers are listed on the back of your member ID card) or use the *Pharmacy Directory.* You can also find information on our website at **http://www.Express-Scripts.com**.

What if you need a specialty pharmacy?
Sometimes prescriptions must be filled at a specialty pharmacy. Specialty pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your LTC pharmacy is not in our network, please contact Customer Service.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations, or that require special handling, provider coordination or education on their use. (Note: This scenario should happen rarely.)

To locate a specialty pharmacy, visit our website at **http://www.Express-Scripts.com**, call Customer Service or look in your *Pharmacy Directory.*

Section 2.3 Using the plan's home delivery service

For certain kinds of drugs, you can use the plan's home delivery service. Generally, the drugs provided through home delivery are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs available through our plan's home delivery service are marked as **mail-order drugs** (MO) in our Drug List.

To get order forms and information about filling your prescriptions by mail, either visit our website at **http://www.Express-Scripts.com** or call Customer Service at the numbers listed on the back of your member ID card.

Usually a home delivery pharmacy order will get to you within 10 days. However, sometimes your home delivery may be delayed. Make sure you have at least a 14-day supply of medication on hand. If you don't have enough, ask your doctor to give you a second prescription for a 30-day supply and fill it at a retail network pharmacy while you wait for your home delivery supply to arrive. If your home delivery shipment is delayed, please call Customer Service.

New prescriptions the pharmacy receives directly from your doctor's office
The pharmacy will automatically fill and deliver new prescriptions it receives from healthcare providers, without checking with you first, if either:

- You used home delivery services with this plan in the previous twelve months, or
- You signed up for automatic delivery of all eligible new prescriptions received directly from healthcare providers. You may request automatic delivery of all new prescriptions now or at any time by contacting Customer Service. The request for automatic deliveries of new prescriptions only lasts until the end of the plan year (which is typically the last day of the calendar year), and you must submit a new request every year and/or each time you change plans.

Please note that not all prescriptions are eligible for automatic delivery. Medications commonly excluded from the program include those not indicated for chronic use (antibiotics, anti-infectives) or prescribed on an as-needed basis (pain medications), as well as medications with legal restrictions, supply limitations or controlled substances.

If you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling Customer Service using the phone numbers on the back of your member ID card.

If you have never used our home delivery service and/or decide to stop automatic fills of new prescriptions, Express Scripts will contact you each time it gets a new prescription from a healthcare provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions received directly from your healthcare provider's office, please contact us by visiting our website at **http://www.Express-Scripts.com** or by calling Customer

Service at the numbers listed on the back of your member ID card.

Refills on home delivery prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program, we will start to process your next refill automatically when our records show you should be close to running out of your drug. Express Scripts will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use our auto refill program, please contact your pharmacy 17 to 21 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares home delivery refills, please contact us by visiting our website at **http://www.Express-Scripts.com** or by calling Customer Service. You should also provide the best ways to contact you by calling Customer Service at the numbers listed on the back of your member ID card. This way, the pharmacy can reach you to confirm your order before shipping.

Section 2.4 How can you get a maintenance supply of drugs?

When you get a maintenance supply of drugs, your cost-sharing amount may be lower. The plan offers two ways to get a long-term supply of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis for a chronic or long-term medical condition.) You may order this supply through mail order (see **Section 2.3**) or at some retail pharmacies.

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. They may accept a lower cost-sharing amount for a long-term supply of maintenance drugs. Other retail pharmacies may not agree to accept this lower cost-sharing amount. In this case, you will be responsible for the difference in price. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service at the numbers listed on the back of your member ID card for more information.
2. For certain kinds of drugs, you can use the plan's **home delivery service. The drugs available through our plan's home delivery service are marked as "MO" drugs in our Drug List.** See **Section 2.3** for more information about using our home delivery service.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations
Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

In a medical emergency. We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care.

When traveling out of the plan's service area. If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. You may be able to order your prescription drugs ahead of time through our home delivery pharmacy service. If you are traveling within the United States and need to fill a prescription because you become ill or you lose or run out of your covered medications, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules. Prior to filling your prescription at an out-of-network pharmacy, call the Customer Service numbers listed on the back of your member ID card to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, Customer Service may be able to

make arrangements for you to get your prescriptions from an out-of-network pharmacy. We cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

To obtain a covered drug in a timely manner. In some cases, you may be unable to obtain a covered drug in a timely manner within our service area. If there is no network pharmacy within a reasonable driving distance that provides 24-hour service, we will cover your prescription at an out-of-network pharmacy.

If a network pharmacy does not stock a covered drug. Some covered prescription drugs (including orphan drugs or other specialty pharmaceuticals) may not be regularly stocked at an accessible retail network pharmacy or through our home delivery pharmacy service. We will cover prescriptions at an out-of-network pharmacy under these circumstances.

In these situations, **please check first with Express Scripts Medicare Customer Service** to see if there is a network pharmacy nearby. Phone numbers for Customer Service are listed on the back of your member ID card. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from the plan?
If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (**Chapter 5, Section 2.1** explains how to ask the plan to pay you back.)

SECTION 3 The plan's Drug List

Section 3.1 The Drug List tells which commonly used Part D drugs are covered

The plan has a 2017 *Formulary (List of Covered Drugs).* In this *Evidence of Coverage,* **we call it the Drug List for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets the requirements set by Medicare and has been approved.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, **Section 1.1** explains about Part D drugs).

We will generally cover a Part D drug as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either:*

- approved by the Food and Drug Administration (FDA). (That is, the FDA has approved the drug for the diagnosis or condition for which it is being prescribed.)
- – *or* – supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor, and for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors.)

The Drug List includes both brand-name and generic drugs
A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. Generally, it works just as well as the brand-name drug and usually costs less. There are generic drug substitutes available for many brand-name drugs.

Your specific plan may also cover over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. To understand your plan's specific coverage, review your *Benefit Overview* or call Customer Service.

What is *not* on the Drug List?
The plan does not cover all prescription drugs. In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more about this, see **Section 7.1** in this chapter).

As mentioned previously, the Drug List does not contain all drugs covered by this plan. The Drug List contains the Part D drugs that are most commonly used by our members. If your drug is not included in the Drug List, you can call Customer Service to find out if we cover it.

Section 3.2 How can you find out if a specific Part D drug is covered by the plan?

You have two ways to find out:

1. Check the most recent Drug List we sent you in the mail. (**Please note:** The Drug List we send to you includes information for the covered drugs that are highly utilized (or most commonly used) by our members. However, we cover additional Part D drugs that are not included in the printed Drug List.
2. Call Customer Service to find out if a particular drug is covered by the plan.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

If there is a restriction for your drug, it usually means that you or your doctor will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See **Chapter 7, Section 5.2** for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once in our Drug List. This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount or form of the drug prescribed by your healthcare provider (for instance, 10mg versus 100mg; one per day versus two per day, tablet versus liquid).

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The following sections tell you more about the types of restrictions we use for certain drugs.

Getting plan approval in advance
For certain drugs, you or your doctor needs to get approval from the plan before we will agree to cover the drug for you. This is called **prior authorization.** Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first
This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **step therapy.**

Quantity limits
For certain drugs, we limit the amount of the drug that you can have. For example, the plan might limit how many refills you can get or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 4.3 Do any of these restrictions apply to your drugs?

To find out if any restrictions apply to a drug you take or want to take, check the plan's Drug List. For the most up-to-date plan-specific information, call Customer Service (phone numbers are listed on the back of your member ID card) or check our website at **http://www.Express-Scripts.com**.

If there is a restriction for a drug, it usually means that you or your doctor will have to take extra steps in order for us to cover the drug. You should contact Customer Service to learn what you or your doctor would need to do to get coverage for the drug. Phone numbers for Customer Service are listed on the back of your member ID card. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See **Chapter 7, Section 5.2** for information about asking for exceptions.)

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

We hope that your drug coverage will work well for you. But it's possible there could be a prescription drug you are currently taking, or one that you and your doctor think you should be taking, that is on our formulary with restrictions. For example:

The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in **Section 4,** some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you.

The drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be. The plan puts covered drugs into different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

Section 5.2 What can you do if your drug is restricted in some way?

If your drug is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your doctor time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply
Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is restricted in some way. Doing this gives you time to talk with your doctor about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer covered by the plan.**
- – *or* – the drug you have been taking is **now restricted in some way** (**Section 4** in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who are new or who were in the plan last year and aren't in a long-term care (LTC) facility:**
  We will cover a temporary supply of a drug that you took during the prior plan year **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the calendar year if you were in the plan last year.** This temporary supply will be for at least 30 days, or less if your prescription is written for fewer days. In that case, you will be allowed multiple fills to provide up to a total of at least a 30-day supply of the medication. The prescription must be filled at a network pharmacy.
- **For those members who are new or who were in the plan last year and reside in an LTC facility:**
  We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you are new and during the first 90 days of the calendar year if you were in the plan last year.** The total supply will be for a maximum of a 98-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 98-day supply of medication. (Please note that the LTC pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those who have been a member of the plan for more than 90 days and reside in an LTC facility and need a supply right away:**
  We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care (LTC) transition supply.

Other times when we will cover at least a temporary 30-day transition supply (or less if you have a prescription written for fewer days) include:

- When you enter an LTC facility
- When you leave an LTC facility
- When you are discharged from a hospital
- When you leave a skilled nursing facility
- When you cancel hospice care
- When you are discharged from a psychiatric hospital with a medication regimen that is highly individualized

To ask for a temporary supply, call Customer Service (phone numbers are listed on the back of your member ID card).

During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug
Start by talking with your doctor. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor find a covered drug that might work for you.

You can ask for an exception
You and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your doctor says that you have medical reasons that justify asking us for an exception, your doctor can help you request an exception to the rule. For example, you can ask the plan to cover a drug that is not currently covered. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you and your doctor want to ask for an exception, **Chapter 7, Section 5.4** explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 Your drug coverage can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make changes to its drug coverage. For example, the plan might:

- **Add or remove drugs from coverage.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from coverage because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see **Section 4** in this chapter).

In almost all cases, we must get approval from Medicare for changes we make to the plan's drug coverage.

Section 6.2 What happens if coverage changes for a drug you are taking?

How will you find out if your drug's coverage has been changed?

If there is a change to coverage *for a drug you are taking,* the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time.**

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from plan coverage. We will let you know of this change right away. Your doctor will also know about this change and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?
If any of the following types of changes affects a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier
- If we put a new restriction on your use of the drug
- If we stop covering a drug, but not because of a sudden recall or because a new generic drug has replaced it

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand-name drug you are taking is replaced by a new generic drug,** the plan must give you at least 60 days' notice or give you a 60-day refill of your brand-name drug at a network pharmacy.
    - During this 60-day period, you should be working with your doctor to switch to the generic or to a different drug that we cover.
    - Or you and your doctor can ask the plan to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see **Chapter 7.**
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
    - Your doctor will also know about this change and can work with you to find another drug for your condition.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to **Chapter 7, Section 5.5.**)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label, as approved by the FDA.
    - Generally, coverage for off-label use is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors. If the use is not supported by any of these reference books, then our plan cannot cover its off-label use.

Also, by law, these categories of drugs are not covered by Medicare Part D plans unless your benefit includes enhanced drug coverage.

- Drugs when used for anorexia, weight loss or weight gain
- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription drugs when used for the relief of cough or colds
- Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations, which are considered Part D drugs)
- Drugs, such as CAVERJECT®, CIALIS®, EDEX®, LEVITRA®, MUSE® and VIAGRA®, when used for the treatment of sexual or erectile dysfunction
- Over-the-counter (OTC) diabetic supplies
- Federal Legend Part B medications – for example, oral chemotherapy agents (e.g., TEMODAR®, XELODA®)
- Non-prescription drugs, also known as over-the-counter (OTC) drugs
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

TRS will provide supplemental coverage in 2017 for the following category of excluded drugs. Please call Customer Service for drug coverage specifics.

- Federal Legend Part B medications, with the exception of Influenza and Pneumonia vaccines and Diabetic Testing Supplies – for example, oral chemotherapy agents (e.g., TEMODAR®, XELODA®)

In addition, if you are **receiving Extra Help from Medicare** to pay for your prescriptions, the Extra Help program will not pay for the drugs not normally covered. Please refer to your formulary or call Customer Service for more information. Phone numbers for Customer Service are listed on the back of your member ID card.

If you receive Extra Help paying for your drugs or have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in the **Appendix.**)

If TRS does provide coverage of drugs not typically covered under a Medicare prescription drug plan, the amount you pay when you fill a prescription for these drugs does not count toward qualifying you for the Catastrophic Coverage stage. (The Catastrophic Coverage stage is described in **Chapter 4, Section 7.**)

SECTION 8 Show your member ID card when you fill a prescription

Section 8.1 Show your member ID card

To fill your prescription, show your member ID card at the network pharmacy you choose. When you show your member ID card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your member ID card with you?

If you don't have your member ID card with you when you fill your prescription, ask the pharmacy to call Express Scripts to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you** for our share. See **Chapter 5, Section 2.1** for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by Original Medicare?

If you are **admitted to a hospital** for a stay covered by Original Medicare, your medical plan through TRS will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

If you are **admitted to a skilled nursing facility** for a stay covered by Original Medicare, your medical plan through TRS will generally cover your prescription drugs during all or part of your stay. If you are still in the skilled nursing facility and your medical plan through TRS is no longer covering your drugs, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

Please Note: When you enter, live in or leave a skilled nursing facility, you are entitled to a Special Enrollment Period. During this time period, you can switch plans or change your coverage. However, this is the only prescription drug plan offered through TRS, and leaving this plan will also terminate your TRS medical plan. (**Chapter 8** tells when you can leave our plan and join a different Medicare plan.)

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your *Pharmacy Directory* to find out if your LTC facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Customer Service. Phone numbers for Customer Service are listed on the back of your member ID card.

What if you're a resident in an LTC facility and become a new member of the plan?
If you need a drug that is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The total supply will be for a maximum of a 98-day supply, or less if your prescription is written for fewer days. (Please note that the LTC pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If needed, we will cover additional refills during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and need a drug that has restrictions on its coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your doctor want to ask for an exception, **Chapter 7, Section 5.4** tells what to do.

Section 9.3 What if you are taking drugs covered by Original Medicare?

Your enrollment in Express Scripts Medicare doesn't affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled in this plan. In addition, if your drug would be covered by Medicare Part A or Part B, our plan can't cover it, even if you choose not to enroll in Part A or Part B.

Some drugs may be covered under Medicare Part B in some situations and through Express Scripts Medicare in other situations. But drugs are never covered by both Part B and our plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or Express Scripts Medicare for the drug.

Section 9.4 What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage (other than through TRS)?

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and lower your premium.

Each year your Medigap insurance company should send you a notice that tells if your prescription drug coverage is creditable and the choices you have for drug coverage. (If the coverage from the Medigap policy is **creditable,** it means that it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The notice will also explain how much your premium would be lowered if you remove the prescription drug coverage portion of your Medigap policy. If you didn't get this notice, or if you can't find it, contact your Medigap insurance company and ask for another copy.

Keep these notices about creditable coverage, because you may need them later. If you enroll in a different Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from the employer or retiree group's benefits administrator.

Section 9.5 What if you are in Medicare-certified Hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an antinausea, laxative, pain medication or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D. **Chapter 4** gives more information about drug coverage and what you pay.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems, such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug for the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking

If we see a possible problem in your use of medications, we will work with your doctor to correct the problem.

Section 10.2 A program to help members manage their medications

We have a Medication Therapy Management (MTM) program that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time and have high drug costs.

This program is voluntary and free to members. A team of pharmacists and doctors developed it for us. The program can help make sure that our members get the most benefit from the drugs they take.

A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your

medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists and other healthcare providers. Also, keep your medication list with you (for example, with your member ID card) in case you go to a hospital or emergency room.

If this program fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about this program, please contact Customer Service (phone numbers are listed on the back of your member ID card).

Chapter 4. Paying for your Part D prescription drugs

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include Extra Help and State Pharmaceutical Assistance Programs (SPAPs). For more information, see the **Appendix.**

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** Please review the notice entitled "Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs" (Low Income Subsidy (LIS) Rider), which tells you about your drug coverage. If you don't have this notice, please call Customer Service and ask for the LIS Rider. Phone numbers for Customer Service are listed on the back of your member ID card.

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in **Chapter 3,** not all drugs are Part D drugs — some drugs are covered under Medicare Part A or Part B and other drugs are excluded by law from Medicare coverage.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions and what rules to follow when you get your covered drugs. Examples of some of the materials where you can find more information about your specific plan include the *Benefit Overview,* the *Quick Reference Guide,* the 2017 *Formulary (List of Covered Drugs)* and any notices you receive from us about changes to your coverage or conditions that affect your coverage.

Chapter 3 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. **Chapter 3** also tells which types of prescription drugs are not covered by our plan.

In most situations, you must use a network pharmacy to get your covered drugs (see **Chapter 3** for the details). The *Pharmacy Directory* has a list of the closest retail pharmacies in the plan's network, as well as other pharmacies in the network. It also explains which pharmacies offer up to a three-month supply.

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services. The amount that you pay for a drug is called "cost-sharing," and there are three ways you may be asked to pay.

- The **"deductible"** is the amount you must pay for drugs before our plan begins to pay its share.
- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

SECTION 2 What you pay for a drug depends on the plan selected by TRS and which drug payment stage you are in when you get the drug

Section 2.1 What are the standard Part D drug payment stages?

As shown in the table on the next page, there are typically four drug payment stages for Medicare Part D plans. The plan selected by TRS will determine if your plan has a Deductible or Coverage Gap stage and how these stages will apply (your other plan materials have more details).

How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind, you are always responsible for the plan's monthly premium (if applicable) regardless of the drug payment stage you are in.

STAGE 1 *Yearly Deductible stage*	**STAGE 2** *Initial Coverage stage*	**STAGE 3** *Coverage Gap stage*	**STAGE 4** *Catastrophic Coverage stage*
You begin in this stage when you fill your first prescription of the plan year at a retail network pharmacy. During this stage, **you pay the full cost** of your drugs. You stay in this stage until you have paid $150 at retail network pharmacies. Prescriptions filled at mail will not be subject to a deductible. (Details are in **Section 4** of this chapter.)	During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** Your share of the cost is shown in your *Benefit Overview* or *Annual Notice of Changes.* After you (or others on your behalf) have met your deductible (if your plan has a deductible), the plan pays its share of the cost of your drugs and you pay your share. You stay in this stage until your year-to-date **"total drug costs"** (your payments plus any Part D plan's payments) total $3,700. (Details are in **Section 5** of this chapter.)	Your cost share in this stage will remain the same as during the Initial Coverage stage. You stay in this stage until your year-to-date **out-of-pocket costs** (your payments) reach a total of $4,950. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in **Section 6** of this chapter.)	During this stage, **the plan will pay most of the cost** of your drugs for the rest of the plan year (through December 31, 2017). (Details are in **Section 7** of this chapter.)

SECTION 3 We will send you a Part D *Explanation of Benefits* (Part D EOB) that explains payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly summary called the Part D *Explanation of Benefits* (the Part D EOB)

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **out-of-pocket** costs.
- We keep track of your **total drug costs.** This is the amount you pay out-of-pocket and/or others pay on your behalf, plus the amount paid by the plan.

We will send you a summary called the Part D *Explanation of Benefits* (Part D EOB) when you have had one or more prescriptions filled through the plan during the previous month. It includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows your total drug costs, including what the plan paid and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs for the year since the year began.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your member ID card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your member ID card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions, go to **Chapter 5, Section 2.**) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
  - When you purchased a covered drug at a network pharmacy at a special price or used a discount card that was not part of our plan's benefit.
  - When you made a copayment for drugs that are provided under a drug manufacturer patient-assistance program.
  - Anytime you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for the Catastrophic Coverage stage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.

- **Check the written report we send you.** When you receive a Part D EOB, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Customer Service (phone numbers are listed on the back of your member ID card). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 During the Deductible stage, you pay the full cost of drugs purchased at retail network pharmacies

Section 4.1 You stay in this stage until you have paid $150 at retail pharmacies

The Deductible stage is the first payment stage for your drug coverage. This stage begins when you fill your first applicable prescription of the plan year. When you are in this payment stage, **you must pay the full cost of your drugs that apply to your deductible** until you reach the plan's deductible amount, which is $150 at retail pharmacies. Prescriptions filled at mail will not be subject to a deductible.

- Your **full cost** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs.
- The **deductible** is the amount you must pay for your Part D prescription drugs before the plan begins to pay its share.

Once you have paid the applicable deductible, you leave the Deductible stage and move on to the next drug payment stage, which is the Initial Coverage stage.

SECTION 5 During the Initial Coverage stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage stage, the plan pays its share of the cost of your covered prescription drugs and you pay your share (your copayment or coinsurance amount). Your share of the cost may vary, depending on the drug and where you fill your prescription.

Your pharmacy choices
How much you pay for a drug depends on whether you get the drug from:

- A retail pharmacy that is in our plan's network
- A pharmacy that is not in the plan's network
- The plan's home delivery pharmacy

For more information about these pharmacy choices and filling your prescriptions, see **Chapter 3** and the plan's *Pharmacy Directory.*

Section 5.2 Your costs for covered Part D drugs

During the Initial Coverage stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **Copayment** means that you pay a fixed amount each time you fill a prescription.
- **Coinsurance** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in other plan documents you have received, the amount of the copayment or coinsurance also depends on which tier your drug is in.

- If your covered drug costs less than the copayment amount listed in your other plan materials, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower.*
- We cover prescriptions filled at out-of-network pharmacies only in limited situations. Please see **Chapter 3, Section 2.5** for information about when we will cover a prescription filled at an out-of-network pharmacy.

Section 5.3 If your doctor provides less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than full month's supply, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the *amount* you pay will be less.
- If you are responsible for a copayment for the drug, your copayment will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.
    - Here's an example: Let's say the copayment for your drug for a full month's supply (a 31-day supply) is $31. This means that the amount you pay per day for your drug is $1. If you receive a 7 days' supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan refill dates for different prescriptions so you can take fewer trips to the pharmacy. The amount you pay will depend on the days' supply you receive.

Section 5.4 You stay in the Initial Coverage stage until your total drug costs for the year reach $3,700

You stay in the Initial Coverage stage until the total amount for the prescription drugs you have filled and refilled reaches the **$3,700 limit for the Initial Coverage stage.**

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What <u>you</u> have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the plan year. (See **Section 6.2** for more information about how Medicare calculates your out-of-pocket costs.) This includes:
    - The deductible you paid when you were in the Deductible stage (if applicable)
    - The total you paid as your share of the cost for your drugs during the Initial Coverage stage
- **What the <u>plan</u> has paid** as its share of the cost for your drugs during the Initial Coverage stage. (If you were enrolled in a different Part D plan at any time during 2017, the amount that plan paid during the Initial Coverage stage also counts toward your total drug costs.)

The Part D EOB that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent for your drugs during the year. Many people do not reach the $3,700 limit in a year.

If you do reach this amount, we'll let you know. You will leave the Initial Coverage stage and move on to the Coverage Gap stage.

Please refer to your other plan materials for your plan-specific coverage in the Initial Coverage stage.

You will remain in the Coverage Gap stage until your total out-of-pocket costs reach $4,950. Once you reach this amount, you will move into the Catastrophic Coverage stage.

SECTION 6 During the Coverage Gap stage, your cost-sharing amounts will remain the same as during the Initial Coverage stage

Section 6.1 You stay in the Coverage Gap stage until your out-of-pocket costs reach $4,950

When you are in the Coverage Gap stage, **your cost-share will remain the same as during the Initial Coverage stage** until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2017, that amount is $4,950.

Please refer to your other plan materials to determine if your plan has a Coverage Gap stage. If your plan does have a Coverage Gap stage, your other plan materials will indicate any additional coverage provided while in this stage.

Medicare Coverage Gap Discount Program
Because you are a member of the TRS-sponsored plan, TRS provides additional coverage in the Coverage Gap stage. After your total yearly drug costs reach $3,700, you will generally pay the same cost-sharing amount as in the Initial Coverage stage until your yearly out-of-pocket drug costs reach $4,950. The benefit that you receive through the TRS plan is generally greater than the one provided under a standard Medicare Part D plan.

In a standard Medicare Part D plan, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand-name drugs to Part D enrollees who either have reached the Coverage Gap stage or have a total drug spend of $3,700 and are not receiving Extra Help. For brand-name drugs, manufacturers provide a 50% discount on the negotiated price (excluding the dispensing fee, if any). The amount you pay and the 50% manufacturer discount would count toward your out-of-pocket costs and move you through the Coverage Gap stage. The amount paid by the plan (10%) does not count toward your out-of-pocket costs.

If you were to leave your TRS plan and enroll in a standard Medicare Part D plan, you would also receive some coverage for generic drugs; however, it works differently than the 50% discount for brand-name drugs. For generic drugs, the amount paid by the plan does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the Coverage Gap stage (the dispensing fee is included as part of the cost of the drug).

If you have any questions about the coverage you receive if you are in the Coverage Gap stage and how the Medicare Coverage Gap Discount Program applies, please contact Customer Service (phone numbers are listed on the back of your member ID card).

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

*These payments **are included** in your out-of-pocket costs*

*When you add up your out-of-pocket costs, **you can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in **Chapter 3**):*

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Deductible stage
  - The Initial Coverage stage
  - The Coverage Gap stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself,** they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.

Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand-name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage stage:

When you (or those paying on your behalf) have spent a total of $4,950 in out-of-pocket costs within the calendar year, you will move on to the Catastrophic Coverage stage.

*These payments are **not** **included** in your out-of-pocket costs*

When you add up your out-of-pocket costs, you are **not** **allowed to include** any of these types of payments for prescription drugs:

- The amount you or TRS pays for your monthly premium
- Drugs you buy outside the United States and its territories
- Drugs that are not covered by our plan
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap stage
- Payments for your drugs that are made by group health plans, including employer health plans
- Payments for your drugs that are made by certain insurance plans and government-funded health programs, such as TRICARE and the Veterans Administration
- Payments for your drugs made by a third party with a legal obligation to pay for prescription costs (for example, workers' compensation)

Reminder: If any other organization, such as the ones listed above, pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Customer Service to let us know (phone numbers are listed on the back of your member ID card).

How can you keep track of your out-of-pocket total?

- **We will help you.** The Part D *Explanation of Benefits* (Part D EOB) summary we send to you includes the current amount of your out-of-pocket costs (**Section 3** in this chapter tells about this report). When you reach a total of $4,950 in out-of-pocket costs for the year, this report will tell you that you have moved on to the Catastrophic Coverage stage.
- **Make sure we have the information we need. Section 3.2** in this chapter tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 7 During the Catastrophic Coverage stage, the plan pays most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage stage when your out-of-pocket costs have reached the $4,950 limit for the calendar year. Once you are in the Catastrophic Coverage stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:

- *–either –* coinsurance of 5% of the cost of the drug
- *–or –* a $3.30 copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage and an $8.25 copayment for all other drugs, with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage.

- **Our plan pays the rest** of the cost.

SECTION 8 What you pay for vaccinations covered by Part D depends on how and where you get them

Section 8.1 Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot

Our plan provides coverage of a number of Part D vaccines. There are two parts to our coverage of vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself.** The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccine.** (This is sometimes called the "administration" of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for)
   - Some vaccines are considered Part D drugs. You can find these vaccines listed in the plan's 2017 *Formulary (List of Covered Drugs).*
   - Other vaccines are considered medical benefits. They are covered under Original Medicare.
2. **Where you get the vaccine medication**
3. **Who gives you the vaccination shot**

What you pay can also vary depending on the circumstances.
For example:

- Sometimes when you get your vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccine, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccine. Remember, you are responsible for all of the costs associated with vaccines (including their administration) during the Deductible and Coverage Gap stages of your benefit (if these stages are applicable). Your actual costs may vary in each stage, depending on your plan design.

Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccine at a network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your copayment or coinsurance for the vaccine and the cost of giving you the vaccine.

- Our plan will pay its share of the cost.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in **Chapter 5.**
- You will be reimbursed the amount you paid, less your normal coinsurance or copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference).

Situation 3: You buy the Part D vaccine at your pharmacy and then take it to your doctor's office, where they give you the vaccine.

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in **Chapter 5.**
- You will be reimbursed the amount charged by the doctor for administering the vaccine.

Section 8.2 You may want to call us before you get a vaccination

The rules for coverage of vaccinations are complicated. We're here to help. We recommend that you call us at Customer Service before getting vaccinated (phone numbers are listed on the back of your member ID card).

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

SECTION 9 Do you have to pay the Part D late enrollment penalty (LEP)?

Section 9.1 What is the Part D LEP?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, the LEP rules do not apply to you. You will not pay an LEP.

You or TRS (on your behalf) may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage, or you experienced a continuous period of 63 days or more when you didn't have creditable prescription drug coverage. The LEP is an amount that is added to your Part D premium. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage.

The penalty may be added to your monthly premium. When you first enroll in Express Scripts Medicare, we let you know the amount of the penalty. If you are responsible for an LEP, it is considered to be part of your plan premium for as long as you have Part D coverage. If you do not pay your LEP, you could be disenrolled for failure to pay your plan premium.

Section 9.2 How much is the Part D LEP?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare prescription drug plan after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For our example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare prescription drug plans in the nation from the previous year. For 2017, this average premium amount is $35.63. This amount may change for 2018.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $35.63, which equals $4.99. This rounds to $5.00. This amount would be added **to the monthly premium amount for someone with an LEP.**

There are three important things to note about this monthly late enrollment penalty:

- First, **the penalty may change each year,** because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
- Third, if you are under 65 and currently receiving Medicare benefits, the LEP will reset when you turn 65. After age 65, your LEP will be based only on the months that you don't have coverage after your Initial Enrollment Period for aging into Medicare.

Section 9.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, there are times when you may not have to pay the LEP.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this **creditable drug coverage.** Please note:
    - Creditable coverage could include drug coverage from a former employer or retiree group, TRICARE or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
        - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.

- The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics and drug discount websites.
- For additional information about creditable coverage, please look in your *Medicare & You* 2017 handbook or call Medicare at 1.800.MEDICARE (1.800.633.4227). TTY users call 1.877.486.2048. You can call these numbers for free, 24 hours a day, 7 days a week.

- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving Extra Help from Medicare.

Section 9.4 What can you do if you disagree about your LEP?

If you disagree about your LEP, you or your representative can ask for a review of the decision about your LEP. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay an LEP. Call Customer Service at the numbers listed on the back of your member ID card to find out more about how to do this.

Important: Do not stop paying your LEP while you're waiting for a review of the decision about your LEP. If you do, you could be disenrolled for failure to pay your plan premiums.

SECTION 10 Do you have to pay an extra Part D amount to Social Security because of your income?

Section 10.1 Who pays an extra Part D amount because of income?

Most people will pay their plan's standard monthly Part D premium. However, some people pay an extra amount because of their yearly income, which is called the Part D Income-Related Monthly Adjustment Amount. If your income is greater than $85,000 for an individual (or married individuals filing separately) or greater than $170,000 for married couples, you must pay an extra amount directly to the government for your Medicare Part D coverage.

If you have to pay an extra amount, the Social Security Administration, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. You must pay the extra amount to the government. It cannot be paid with your monthly plan premium.

Section 10.2 How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your Internal Revenue Service (IRS) tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium.

The table on the next page shows the extra amount based on your income.

If you filed an individual tax return and your income in 2015 was:	If you were married but filed a separate tax return and your income in 2015 was:	If you filed a joint tax return and your income in 2015 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)
Equal to or less than $85,000	Equal to or less than $85,000	Equal to or less than $170,000	$0
Greater than $85,000 and less than or equal to $107,000		Greater than $170,000 and less than or equal to $214,000	$13.30
Greater than $107,000 and less than or equal to $160,000		Greater than $214,000 and less than or equal to $320,000	$34.20
Greater than $160,000 and less than or equal to $214,000	Greater than $85,000 and less than or equal to $129,000	Greater than $320,000 and less than or equal to $428,000	$55.20
Greater than $214,000	Greater than $129,000	Greater than $428,000	$76.20

Section 10.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask the Social Security Administration to review the decision. To find out more about how to do this, contact the Social Security Administration at 1.800.772.1213. Automated services are available 24 hours a day, 7 days a week. You can speak with a representative between 7 a.m. and 7 p.m., Eastern Time, Monday through Friday. TTY users should call 1.800.325.0778.

Section 10.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. **If you are required to pay the extra amount and you do not pay it, you <u>will</u> be disenrolled from the plan and lose prescription drug coverage.** If you are disenrolled from the plan, your TRS medical coverage will also be terminated.

SECTION 11 Information about programs to help people pay for their prescription drugs

Medicare's Extra Help Program

Medicare provides Extra Help to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible and prescription copayments or coinsurance. This Extra Help also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for Extra Help. Some people automatically qualify for Extra Help and don't need to apply. Medicare mails a letter to people who automatically qualify for Extra Help.

There are programs in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your local Medical Assistance (Medicaid) office to find out more about their rules (the phone number is in the **Appendix**). Or call 1.800.MEDICARE (1.800.633.4227) 24 hours a day, 7 days a week and say "Medicaid" for more information. TTY users should call 1.877.486.2048. You can also visit http://www.medicare.gov for more information.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for getting Extra Help, call:

- 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1.800.772.1213, between 7:00 a.m. and 7:00 p.m., Eastern Time, Monday through Friday. TTY users should call 1.800.325.0778 (applications); or
- Your State Medicaid Office (applications). (See the **Appendix** for contact information.)

If you believe you have qualified for Extra Help and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you either to request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

We may be able to accept one of the following forms of Best Available Evidence (BAE) to establish that you qualify for Extra Help, when the evidence is provided by you or your pharmacist, advocate, representative, family member or other individual acting on your behalf:

1. A copy of the beneficiary's Medicaid card that includes the beneficiary's name and an eligibility date during any month after June of the previous calendar year;
2. A copy of a state document that confirms active Medicaid status during any month after June of the previous calendar year;
3. A printout from the state electronic enrollment file showing Medicaid status during any month after June of the previous calendar year;
4. A screen print from the state's Medicaid systems showing Medicaid status during any month after June of the previous calendar year;
5. Other documentation provided by the state showing Medicaid status during any month after June of the previous calendar year;
6. A letter from the Social Security Administration (SSA) showing that the individual receives Supplemental Security Income (SSI); or,
7. An Application Filed by Deemed Eligible confirming that the beneficiary is "…automatically eligible for extra help…" (SSA publication HI 03094.605)

The following proofs of institutional status are acceptable from the beneficiary or the beneficiary's pharmacist, advocate, representative, family member or other individual acting on behalf of the beneficiary to establish that a beneficiary is institutionalized, beginning on a date specified by the Secretary:

1. A remittance from the facility showing Medicaid payment for a full calendar month for that individual during any month after June of the previous calendar year;

2. A copy of a state document that confirms Medicaid payment on behalf of the individual to the facility for a full calendar month after June of the previous calendar year;
3. A screen print from the state's Medicaid systems showing that individual's institutional status based on at least a full calendar-month stay for Medicaid payment purposes during any month after June of the previous calendar year.

The following proofs of status are acceptable from the beneficiary or the beneficiary's pharmacist, advocate, representative, family member or other individual acting on behalf of the beneficiary to establish that an individual is receiving home and community-based services (HCBS) and qualifies for zero cost-sharing effective as of a date specified by the Secretary:

1. A State-issued Notice of Action, Notice of Determination or Notice of Enrollment that includes the beneficiary's name and HCBS eligibility date during a month after June of the previous calendar year;
2. A State-approved HCBS Service Plan that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;
3. A State-issued prior authorization approval letter for HCBS that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;
4. Other documentation provided by the State showing HCBS eligibility status during a month after June of the previous calendar year; or,
5. A State-issued document, such as a remittance advice, confirming payment for HCBS, including the beneficiary's name and the dates of HCBS.

You or your representative may fax or mail Best Available Evidence to the following fax number or address:

Fax: **1.855.297.7271**
Address: **Express Scripts Medicare (PDP)**
P.O. Box 4558
Scranton, PA 18505

When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment, or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions.

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?
If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than Extra Help), you still get the 50% discount on covered brand-name drugs. The 50% discount and the 10% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?
What is the AIDS Drug Assistance Program (ADAP)?
The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription drug cost-sharing assistance in those states that have this program. Note: To be eligible for the ADAP operating in your state, individuals must meet certain criteria, including

proof of state residence and HIV status, low income as defined by the state, and uninsured/underinsured status.

If you are currently enrolled in an ADAP, it may continue to provide you with Medicare Part D prescription drug cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. For information on eligibility criteria, covered drugs, or how to enroll in the program, please refer to the contact information located in the **Appendix.**

What if you get Extra Help from Medicare to help pay your prescription drug costs? Can you get the discounts?
No. If you get Extra Help, you already get coverage for your prescription drug costs during the Coverage Gap.

What if you don't get a discount and you think you should have?
If you think that you have reached the Coverage Gap and did not get a discount when you paid for your brand-name drug, you should review your next Part D *Explanation of Benefits* (Part D EOB) notice. If the discount doesn't appear on your Part D EOB, you should contact us to make sure that your prescription records are correct and up to date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in the **Appendix**) or by calling 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

State Pharmaceutical Assistance Programs (SPAPs)
Many states have State Pharmaceutical Assistance Programs (SPAPs) that help some people pay for prescription drugs based on financial need, age or medical condition or disabilities. Each state has different rules for providing drug coverage to its members. These programs provide limited-income and medically needy seniors and individuals with disabilities financial help for prescription drugs. Contact information for SPAPs is located in the **Appendix.**

Chapter 5. Asking us to pay our share of the costs for covered drugs

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered drugs

Section 1.1 If you pay our plan's share of the cost of your covered drugs, you can ask us for payment

Sometimes when you get a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you).

Here are examples of situations in which you may need to ask our plan to pay you back. All of these examples are types of coverage decisions (for more information about coverage decisions, go to **Chapter 7**).

1. **When you use an out-of-network pharmacy to get a prescription filled**
   If you go to an out-of-network pharmacy and try to use your member ID card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to **Chapter 3, Section 2.5** to learn more.)
   - Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.
2. **When you pay the full cost for a prescription because you don't have your member ID card with you**
   If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or look up your enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.
   - Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.
3. **When you pay the full cost for a prescription in other situations**
   You may pay the full cost of the prescription because you find that the drug is not covered for some reason.
   - For example, the drug may have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it. Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.
   - If you are requesting payment for coverage of a Part D vaccine, such as a vaccine drug or administration of a vaccine drug, please save your invoice (bill) from your doctor and send a copy to us when you ask us to pay you back for our share of the cost.
   - In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.
4. **If you are retroactively enrolled in our plan**
   Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.) If you were retroactively enrolled in our plan and you paid out of pocket for any of your drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

- Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request. Phone numbers for Customer Service are listed on the back of your member ID card.

5. **In a medical emergency**
   We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.
6. **When traveling away from our plan's service area**
   If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. You may be able to order your prescription drugs ahead of time through our home delivery pharmacy service. If you are traveling within the United States and need to fill a prescription because you become ill or you lose or run out of your covered medications, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules. Prior to filling your prescription at an out-of-network pharmacy, call the Customer Service numbers listed on the back of your member ID card to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, Customer Service may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy. We cannot pay for any prescriptions that are filled outside the United States, even for a medical emergency.
7. **To obtain a covered drug in a timely manner**
   In some cases, you may be unable to obtain a covered drug in a timely manner within our service area. If there is no network pharmacy within a reasonable driving distance that provides 24-hour service, we will cover your prescription at an out-of-network pharmacy. Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.
8. **If a network pharmacy does not stock a covered drug**
   Some covered prescription drugs (including orphan drugs or other specialty pharmaceuticals) may not be regularly stocked at an accessible network retail pharmacy or through our home delivery pharmacy. We will cover prescriptions at an out-of-network pharmacy under these circumstances. Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. **Chapter 7** has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with a copy of your pharmacy prescription receipt or your pharmacy patient history printout signed by the dispensing pharmacist. A copy of an invoice (bill) is required for all other requests for payment, such as claims for vaccines from a physician or claims for Medicare Part D drugs from a hospital or clinic. It's a good idea to keep the original receipts or invoices, or to make copies, for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website, **http://www.Express-Scripts.com**, or call Customer Service and ask for a "Direct Claim Form." The phone numbers for Customer Service are listed on the back of your member ID card.

Mail your request for payment, together with any receipts, to us at this address:

Express Scripts
Attn: Medicare Part D
P.O. Box 14718
Lexington, KY 40512-4718

You also have the option of faxing your claim form and receipts to **1.608.741.5483.**

You must submit your claim to us within 36 months of the date you received the service, item or drug.

Please be sure to contact Customer Service if you have any questions. Phone numbers for Customer Service are listed on the back of your member ID card. If you don't know what you should have paid, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will review your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. We will mail your reimbursement of our share of the cost to you. (**Chapter 3** explains the rules you need to follow for getting your Part D prescription drugs covered.) We will send payment within 14 days after your request was received.
- If we decide that the drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to **Chapter 7.** The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading **Section 4** of **Chapter 7. Section 4** is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then, after you have read **Section 4,** you can go to **Section 5.5** in **Chapter 7** for a step-by-step explanation of how to file an appeal.

SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. **When you buy the drug for a price that is lower than our price**
   Sometimes when you are in the Deductible stage and/or Coverage Gap stage (if they apply to your plan), you may be able to buy your drug **at a network pharmacy** for a price that is lower than our price.
   - For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
   - Unless special conditions apply, you must use a network pharmacy in these situations.
   - Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage stage.
   - **Please note:** If you are in the Deductible stage and/or Coverage Gap stage (if they apply to your plan and the plan does not provide coverage in the gap), we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage stage more quickly.
2. **When you get a drug through a patient assistance program offered by a drug manufacturer**
   Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.
   - Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage stage.
   - **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

Chapter 6. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member

Section 1.1 We must provide information in a way that works for you (in languages other than English, in braille or in other alternate formats, etc.)

To get information from us in a way that works for you, please call Customer Service (phone numbers are listed on the back of your member ID card).

Our plan has people and free language interpreter services available to answer questions from non-English-speaking members. We can also give you information in braille or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or a disability, please call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week and tell them that you want to file a complaint. TTY users call 1.877.486.2048.

Sección 1.1 Debemos brindar información de tal forma que le sea útil (en español, en braille, o otros formatos alternativos, etc.)

Para obtener información nuestra de tal forma que le sea útil, llame al Servicio al cliente (los números de teléfono se encuentran al dorso de su tarjeta de ID de miembro).

Nuestro plan cuenta con servicios disponibles de intérprete de idiomas sin cargo y personas para responder preguntas de miembros que no hablan inglés. Además, podemos brindarle información en braille u otros formatos alternativos si a necesita. Si es elegible para Medicare debido a una incapacidad, debemos brindarle información sobre los beneficios del plan que es accesible y adecuado para usted.

Si tiene problemas para obtener información de nuestro plan debido a problemas relacionados con el idioma o incapacidad, llame a Medicare al 1.800.MEDICARE (1.800.633.4227), las 24 horas del día, los 7 días de la semana, e infórmeles que desea presentar una queja. Los usuarios de TTY deben llamar al 1.877.486.2048.

Section 1.2 We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1.800.368.1019 for recorded information (TTY users call 1.800.537.7697). You can also visit their website at http://www.hhs.gov/ocr/ or contact your regional Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Service (phone numbers are listed on the back of your member ID card). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 1.3 We must ensure that you get timely access to your covered drugs

As a member of our plan, you have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your Part D drugs within a reasonable amount of time, **Chapter 7, Section 7** tells what you can do. (If we have denied coverage for your prescription drugs and you don't agree with our decision, **Chapter 7, Section 4** tells what you can do.)

Section 1.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the personal information you gave us when you enrolled in this plan, as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practices,* that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information, including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held by the plan and to get a copy of your records. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your doctor to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are listed on the back of your member ID card).

Section 1.5 We must give you information about the plan, its network of pharmacies and your covered drugs

As a member of Express Scripts Medicare, you have the right to get several kinds of information from us. (As explained in **Section 1.1,** you also have the right to get information from us in a way that works for you. This includes getting the information in languages other than English, in braille or in other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are listed on the back of your member ID card):

- **Information about our plan**
  This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members.
- **Information about our network pharmacies**
  - For example, you have the right to get information from us about the pharmacies in our network.
  - For a list of the retail pharmacies in your area and others that are in the plan's network, see the *Pharmacy Directory.*
  - For more detailed information about our pharmacies, you can call Customer Service (phone numbers are listed on the back of your member ID card) or visit our website at **http://www.Express-Scripts.com**.
- **Information about your coverage and rules you must follow when using your coverage**
  - To get the details on your Part D prescription drug coverage, see **Chapters 3** and **4,** plus the plan's 2017 *Formulary (List of Covered Drugs).* These chapters, together with the 2017 *Formulary (List of Covered Drugs),* tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are listed on the back of your member ID card).
- **Information about why something is not covered and what you can do about it**
  - If your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the drug from an out-of-network pharmacy.
  - If you are not happy, or if you disagree with a decision we make about how a Part D drug is covered for you, you have the right to make an appeal and ask us to change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see **Chapter 7.** It gives you the details about how to make an appeal if you want us to change our decision. (**Chapter 7** also tells about how to make a complaint about quality of care, waiting times and other concerns.)
  - If you want to ask our plan to pay our share of the cost for a Part D prescription drug, see **Chapter 5.**

Section 1.6 We must support your right to make decisions about your care

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make healthcare decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called **advance directives.** There are different types of advance directives and different names for them.

Documents called a **living will** and a **power of attorney for healthcare** are examples of advance directives.

If you want to use an advance directive to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the appropriate agency in your state, such as the Department of Health.

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, **Chapter 7** tells what you can do. It gives the details about how to deal with all types of problems and complaints.

What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision or make a complaint. Whatever you do—ask for a coverage decision, make an appeal or make a complaint—**we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service (phone numbers are listed on the back of your member ID card).

Section 1.8 What can you do if you think you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1.800.368.1019 for recorded information (TTY users call 1.800.537.7697). You can also visit their website at http://www.hhs.gov/ocr/ or contact your regional Office for Civil Rights.

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected and it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Service** (phone numbers are listed on the back of your member ID card).
- You can **call the State Health Insurance Assistance Program.** For details about this organization, go to **Chapter 2;** for information on how to contact it, go to the **Appendix.**
- Or, **you can call Medicare** at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

Section 1.9 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Customer Service** (phone numbers are listed on the back of your member ID card).
- You can **call the State Health Insurance Assistance Program.** For details about this organization, go to **Chapter 2;** for information on how to contact it, go to the **Appendix.**
- You can contact **Medicare.**
    - You can visit the Medicare website to read or download the publication, "Your Medicare Rights and Protections." (The publication is available at: http://www.medicare.gov/Pubs/pdf/11534.pdf.)
    - Or, you can call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are listed on the back of your member ID card). We're here to help.

- ***Get familiar with your covered drugs and the rules you must follow to get these covered drugs.*** *Use this Evidence of Coverage along with your formulary and other plan documents you have received to learn what's covered and the rules you need to follow to get your covered drugs.*
    - **Chapters 3** and **4** give the details about your coverage for Part D prescription drugs.
- ***If you have any other prescription drug coverage in addition to our plan, you are required to tell us.*** *Please call Customer Service to let us know (phone numbers are listed on the back of your member ID card).*
    - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered drugs from our plan. This is called **coordination of benefits** because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to **Chapter 1, Section 7.**)

- ***Tell your doctor and pharmacist that you are enrolled in our plan.*** *Show your member ID card whenever you get your Part D prescription drugs.*
- ***Help your doctors and other providers help you by giving them information, asking questions and following through on your care.***
    - To help your doctors and other healthcare providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins and supplements.
    - If you have any questions, be sure to ask. Your doctors and other healthcare providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- ***Pay what you owe.*** *As a plan member, you are responsible for these payments:*
    - If you are responsible for a premium, you must pay it to continue being a member of this plan.
    - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount) *or* coinsurance (a percentage of the total cost). Your *Benefit Overview* or *Annual Notice of Changes* will tell you what you must pay for your Part D prescription drugs.
    - If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
    - If you disagree with our decision to deny coverage for a drug, you can make an appeal. Please see **Chapter 7** for information about how to make an appeal.
    - If you are required to pay a late enrollment penalty (LEP), you must pay the penalty to remain a member of the plan.
    - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.
- ***Tell us if you move.*** *If you are going to move, it's important to tell us right away. Call TRS.*
    - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (**Chapter 1** tells about our service area.)
    - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
    - If you move, it is also important to tell Social Security. You can find the phone numbers and contact information for Social Security in **Chapter 2.**
- ***Call Customer Service for help if you have questions or concerns.*** *We also welcome any suggestions you may have for improving our plan.*
    - Phone numbers for Customer Service are listed on the back of your member ID card.
    - For more information on how to reach us, including our mailing address, please see **Chapter 2.**

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Background

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- One for **coverage decisions and making appeals**
- And another process **for making complaints**

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in **Section 3** will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “coverage determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful—and sometimes quite important—for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through with the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization
We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected to us. You can always contact your **State Health Insurance Assistance Program (SHIP).** This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in the **Appendix.**

You can also get help and information from Medicare
For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.
- You can visit the Medicare website (http://www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**	
Is your problem or concern about your benefits or coverage? (This includes problems about whether particular prescription drugs are covered or not, the way in which they are covered and problems related to payment for prescription drugs.)	
Yes. My problem is about benefits or coverage. Go on to the next section of this chapter, **Section 4: A guide to the basics of coverage decisions and appeals.**	**No.** My problem is not about benefits or coverage. Skip ahead to **Section 7** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for prescription drugs, including problems related to payment. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered.

Asking for coverage decisions
A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal
If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain circumstances which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can ask for a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Customer Service** (phone numbers are listed on the back of your member ID card).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see **Section 2** of this chapter for more information).
- **For your Part D prescription drugs,** your doctor or other prescriber can request a coverage decision or a Level 1 or 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other provider must be appointed as your representative.

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under State law.
    - If you want a friend, relative, your doctor or other prescriber or any other person to be your representative, call Customer Service (phone numbers for Customer Service are listed on the back of your member ID card) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.) The "Appointment of Representative" form gives that person permission to act on your behalf. It must be signed by you and by the person whom you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

SECTION 5 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

? Have you read **Section 4** of this chapter, *A guide to the basics of coverage decisions and appeals?* If not, you may want to read it before you start this section.

Section 5.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to the 2017 *Formulary (List of Covered Drugs).* To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the FDA or supported by certain reference books. See **Chapter 3, Section 3** for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the 2017 *Formulary (List of Covered Drugs),* rules and restrictions on coverage and cost information, see **Chapter 3** and **Chapter 4.**

Part D coverage decisions and appeals

As discussed in **Section 4** of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal terms	An initial coverage decision about your Part D drugs is called a **coverage determination.**

Here are examples of coverage decisions you may ask us to make about your Part D drugs:

- You ask us to make an exception, including:
    - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
    - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is covered by the plan, but we require you to get approval from us before we will cover it for you.)
    - Please note: If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice from the pharmacy explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?			
Do you want us to waive a rule or restriction on a drug we cover?	**Do you believe you have met any plan rules or restrictions (such as getting approval in advance) for the drug you need?**	**Do you want to ask us to pay you back for a drug you have already received and paid for?**	**Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?**
You can ask us to make an exception. (This is a type of coverage decision.)	You can ask us for a coverage decision.	You can ask us to pay you back. (This is a type of coverage decision.)	You can make an appeal. (This means you are asking us to reconsider.)
Start with **Section 5.2** of this chapter.	Skip ahead to **Section 5.4** of this chapter.	Skip ahead to **Section 5.4** of this chapter.	Skip ahead to **Section 5.5** of this chapter.

Section 5.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs we cover (for more information, go to **Chapter 3**).

Legal terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for an **exception.**

   - The extra rules and restrictions on coverage for certain drugs include:
     - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called **prior authorization.**)
     - *Being required to try a different drug first* before we agree to cover the drug you are asking for. (This is sometimes called **step therapy.**)
     - *Quantity limits*. For some drugs, there are restrictions on the amount of the drug you can have.
   - If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in a specific cost-sharing tier. You can see what tier a drug is in by looking in your 2017 *Formulary (List of Covered Drugs).* In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal terms	Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a **tiering exception.**

   - If your drug is in our Non-Preferred Drug Tier, you can ask us to cover it at a lower cost-sharing amount that applies to drugs in our Preferred Brand Tier. This would lower your share of the cost for the drug.
   - You cannot ask us to change the cost-sharing tier for any drug in our Specialty Tier.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our plan's coverage includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally

not approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you.

We can say yes or no to your request

- If we approve your request for an exception, our approval is typically valid for 12 months. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. **Section 5.5** tells you how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 5.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1 You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "fast coverage decision." You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What to do

- **Request the type of coverage decision you want.** Start by calling, writing or faxing us to make your request. You, your authorized representative or your doctor (or other prescriber) can do this. You can also access information about the coverage decision process through our Web site. For the details, go to **Chapter 2, Section 1** and look for the section called *How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs.* Or if you are asking us to pay you back for a drug, go to the section called *Where to send a request asking us to pay for our share of the cost of a drug you have received.*
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. **Section 4** of this chapter tells how you can give written permission to someone else to act as your authorized representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug,** start by reading **Chapter 5,** which describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the supporting statement.** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See **Sections 5.2** and **5.3** for more information about exception requests.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website at **www.Express-Scripts.com**.

If your health requires it, ask us to give you a fast coverage decision

Legal terms	A fast coverage decision is called an **expedited coverage determination.**

- When we give you our coverage decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement.

- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received.* (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage decision *only* if using *the standard deadlines could cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see **Section 7** of this chapter.)

Step 2 We consider your request and we give you our answer.

Deadlines for a **fast** coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours.**
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to do so.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how to appeal the descision.

Deadlines for a **standard** coverage decision about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a **written statement** that explains why we said no. We will also tell you how to appeal the decision.

Deadlines for a **standard** coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how to appeal the descision.

Step 3 If we say no to your coverage request, you decide if you want to make an appeal.

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider—and possibly change—the decision we made.

Section 5.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

Legal terms	An appeal to the plan about a Part D drug coverage decision is called a plan **redetermination.**

Step 1 You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a **fast appeal.**

What to do

- **To start your appeal, you (or your authorized representative or your doctor or other prescriber) must contact us.**
    - For details on how to reach us by phone, fax, or mail, or on our website for any purpose related to your appeal, go to **Chapter 2, Section 1** and look for the section called *How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.** You may also ask for an appeal by calling us at the phone numbers shown in **Chapter 2, Section 1** *(How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs.)*
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone numbers shown in Chapter 2, Section 1** *(How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs.)*
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
    - You have the right to ask us for a copy of the information regarding your appeal.
    - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a fast appeal

Legal terms	A fast appeal is also called an **expedited reconsideration.**

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast decision in **Section 5.4** of this chapter.

Step 2 We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a **fast appeal**

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal request.** We will give you our answer sooner if your health requires it.
    - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a **standard appeal**

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for a "fast" appeal.
    - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
    - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal request.
    - If we approve a request to pay **you back for a drug** you already bought, we are required to **send payment to you within 30 calendar days after we receive** your appeal request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Step 3 If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 5.6 Step-by-step: How to make a Level 2 Appeal

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal terms	The formal name for the Independent Review Organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

Step 1 To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2 The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for **fast appeal** at Level 2

- If your health requires it, ask the Independent Review Organization for a fast appeal.
- If the review organization agrees to give you a fast appeal, the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for **standard appeal** at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested**

- If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

If the Independent Review Organization "upholds the decision," you have the right to a Level 3 appeal. However, to continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3 If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge. **Section 6** in this chapter tells more about Levels 3, 4 and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

Section 6.1 Levels of Appeal 3, 4 and 5 for Part D drug appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: **A judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over.**
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal: The **Appeals Council** will review your appeal and give you an answer. The Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal: A judge at the **Federal District Court** will review your appeal and make a decision.

- This is the last step of the appeals process.

Making complaints

SECTION 7 How to make a complaint about quality of care, waiting times, customer service or other concerns

? If your problem is about decisions related to benefits, coverage or payment, then this section is *not for you.* Instead, you need to use the process for coverage decisions and appeals. Go to **Section 4** of this chapter.

Section 7.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of the following kinds of problems or concerns, you can make a complaint:

- If you are unhappy with the quality of care received
- If you feel someone did not respect your right to privacy or has shared information you feel should be confidential
- If you feel someone treated you disrespectfully
- If you received poor customer service
- If you feel you are being encouraged to leave the plan
- If you were kept waiting too long at the pharmacy or by Customer Service
- If you are unhappy with the condition or cleanliness of the pharmacy
- If you feel we have not given you a notice we are required to give or that written information was too difficult to understand

These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals.

The process of asking for a coverage decision and making appeals is explained in **Sections 4–6** of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast response" for a coverage decision or appeal and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.

When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 7.2 The formal name for making a complaint is filing a grievance

Legal terms	• What this section calls a **complaint** is also called a **grievance.** • Another term for **making a complaint** is **filing a grievance.** • Another way to say **using the process for complaints** is **using the process for filing a grievance.**

Section 7.3 Step-by-step: Making a complaint

Step 1 Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know. Call us at the phone numbers listed on the back of your member ID card.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
    - If you call to make a complaint, an attempt will be made to resolve your complaint over the phone. If we cannot resolve your complaint over the phone, we will respond within 30 days.

  - If you prefer to make your complaint in writing, please send a letter with as much detail as possible to: Express Scripts Medicare, Attn: Grievance Resolution Team, P.O. Box 3610, Dublin, OH 43016-0307. All written complaints will be responded to within 30 days.
  - If you have a grievance regarding a denial for a request for a "fast coverage decision" or a "fast appeal," we will give you an answer within 24 hours.

- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a fast response to a coverage decision or appeal, we will automatically give you a fast complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours.**

Legal terms	What this section calls a **fast complaint** is also called an **expedited grievance.**

Step 2 We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 7.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received by using the step-by-step process outlined above.

When your complaint is about *quality of care,* you also have two additional options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other healthcare experts paid by the Federal government to check and improve the care given to Medicare patients.
  - To find the name, address and phone number of the Quality Improvement Organization for your state, look in the **Appendix.** If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about Express Scripts Medicare directly to Medicare. To submit a complaint to Medicare, go to http://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1.800.MEDICARE (1.800.633.4227). TTY users can call 1.877.486.2048.

Chapter 8. Ending your membership in this plan

Note: This chapter contains general information on disenrollment from a Medicare Part D plan and member options. For specific options available to you as a member of a retiree group-sponsored plan or for more information, please contact TRS.

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in this plan

Ending your membership in Express Scripts Medicare may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave this plan because you *or* TRS has decided to end your membership. **You should always check with TRS before leaving this plan.**
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in a Medicare Part D plan. **Section 2** tells you *when* you can end your membership in this plan. **As a member of a group-sponsored plan (such as this plan), you may end your membership in this plan at any time throughout the year and you will be granted a Special Enrollment Period. Please contact TRS for more information before making a decision to do so to ensure that you understand any additional implications of leaving this plan (for example: loss of medical or dental benefits).**
  - The process for voluntarily ending your membership varies, depending on what type of new coverage you are choosing. **Section 3** tells you *how* to end your membership.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. **Section 5** tells you about situations when we must end your membership.

If you are leaving this plan, you must continue to get your Part D prescription drugs through this plan until your membership ends. **Ending membership in this plan will also terminate your TRS medical coverage, and you might not be eligible for future TRS enrollment.**

SECTION 2 When can you end your membership in this plan?

You may end your membership in our plan on the last day of the month following receipt of your written request to TRS at 479 Versailles Road, Frankfort, KY 40601. **Your decision to leave this plan will also terminate your TRS medical coverage, and you might not be eligible for future TRS enrollment. Always check with TRS before terminating this plan.**

You may also end your membership during other times of the year, known as enrollment periods. All members have the opportunity to leave their plan during the Medicare Annual Enrollment Period. In certain situations, you may also be eligible to leave this plan at other times of the year.

Section 2.1 Usually, you can end your membership during the Medicare Annual Enrollment Period

You can end your membership during the **Medicare Annual Enrollment Period** (also known as the Annual Coordinated Election Period). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Medicare Annual Enrollment Period?** This happens from October 15 to December 7 every year. **TRS may have established an open enrollment period with different timing during which you may elect changes. Please contact TRS for more information about their open enrollment period.**
    - **Since you are a member of a group-sponsored plan, you should contact TRS for information regarding any other plan options available to you, as well as any implications of leaving this plan (such as loss of medical or dental benefits).**
- **When will your membership end? Your membership will end when your new plan's coverage begins on January 1. Enrolling in another plan will terminate this TRS plan and will also terminate your TRS medical coverage, and you might not be eligible for future TRS enrollment.**

Section 2.2 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Express Scripts Medicare may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period.**

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples of special enrollment periods that are available. For the full list, you can contact the plan, call Medicare or visit the Medicare website (http://www.medicare.gov):
    - If you have moved out of your plan's service area
    - If you have Medicaid
    - If you are eligible for Extra Help with paying for your Medicare prescriptions
    - If we violate our contract with you
    - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital
    - If you enroll in the Program of All-inclusive Care for the Elderly (PACE). **Note:** PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Service at the numbers located on the back of your member ID card.
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage.

Section 2.3 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can call TRS at **1.800.618.1687.**
- You can **call Customer Service** (phone numbers are listed on the back of your member ID card).
- You can find the information in the *Medicare & You* 2017 handbook.
    - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
    - You can also download a copy from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the numbers below.

- You can contact **Medicare** at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

SECTION 3 How do you end your membership in this plan?

For information about disenrolling from this plan, contact TRS. They can best explain your options, the implications of leaving this plan and the process to follow to disenroll.

SECTION 4 Until your membership ends, you must keep getting your drugs through this plan

Section 4.1 Until your membership ends, you are still a member of this plan

If you leave Express Scripts Medicare, it may take time before your membership ends and your new Medicare coverage goes into effect. (See **Section 2** for information on when your new coverage begins.) During this time, you should continue to get your prescription drugs through this plan.

- **In order to have coverage through this plan until your new coverage starts, you should continue to use our network pharmacies to get your prescriptions filled until your membership in this plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy, including through our home delivery pharmacy service.

SECTION 5 Express Scripts Medicare must end your membership in certain situations

Section 5.1 When must we end your membership?

Express Scripts Medicare must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A or Part B (or both).
- If you move out of our service area for more than 12 months.
  - If you move or take a long trip, you need to call Customer Service (phone numbers are listed on the back of your member ID card) to find out if the place you are moving or traveling to is in this plan's service area.
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in this plan and that information affects your eligibility for this plan. (We cannot make you leave this plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of this plan. (We cannot make you leave this plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your member ID card to get prescription drugs. (We cannot make you leave this plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay any plan premiums you are responsible for according to your group's premium payment policy.

  - The plan must notify you in writing that you have a grace period to pay the plan premium before we end your membership. Contact TRS for more information about your plan premium and the grace periods for paying your plan premium.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from this plan and you will lose prescription drug coverage.

Where can you get more information?
If you have questions or would like more information on when we can end your membership, you can call **Customer Service** (phone numbers are listed on the back of your member ID card).

Section 5.2 We cannot ask you to leave this plan for any reason related to your health

Express Scripts Medicare is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?
If you feel that you are being asked to leave this plan because of a health-related reason, you should call Medicare at 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in this plan

If we end your membership in this plan, we must tell you our reasons in writing for ending your membership. We must also explain how to file a grievance or how to make a complaint about our decision to end your membership. You can also look in **Chapter 7, Section 7** for information about how to make a complaint.

Chapter 9. Legal notices

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. All organizations that provide Medicare prescription drug plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, and all other laws that apply to organizations that get Federal funding and any other laws and rules that apply for any other reason.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Express Scripts Medicare, as a Medicare prescription drug plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR, and the rules established in this section supersede any State laws.

Chapter 10. Definitions of important words

2017 ***Formulary (List of Covered Drugs)*** or **Drug List** – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs. This list contains the most commonly used drugs and does not include all Part D drugs covered by this plan.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received. For example, you may ask for an appeal if we don't pay for a drug you think you should be able to receive. **Chapter 7** explains appeals, including the process involved in making an appeal.

Brand-name drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand-name drug has expired.

Catastrophic Coverage stage – The stage in the Part D drug benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,950 on covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. **Chapter 2** explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for prescription drugs after you pay any deductibles (if they apply). Coinsurance is usually a percentage (for example, 20%).

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times and the customer service you receive. See also "Grievance" in this list of definitions.

Copayment – An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a prescription drug.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when drugs are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed copayment amount that a plan requires when a specific drug is received; or (3) any coinsurance amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is received. A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment.

Coverage determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the medication isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this document. **Chapter 7** explains how to ask us for a coverage decision.

Covered drugs – The term we use to mean all of the prescription drugs covered by this plan.

Creditable prescription drug coverage – Prescription drug coverage (for example, from an employer or retiree group) that is expected to pay, on average, at least as much as Medicare's standard prescription drug

coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Customer Service – A department within this plan responsible for answering your questions about your membership, benefits and filing grievances. See the back of your member ID card for information about how to contact Customer Service.

Daily cost-sharing rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $31 and a one-month's supply in your plan is 31 days, then your "daily cost-sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription.

Deductible – The amount you must pay for prescriptions before this plan begins to pay (if your plan has a deductible).

Disenroll or **Disenrollment** – The process of ending your membership in this plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Drug Tier (Cost-sharing Tier) – Each drug on our drug list is placed in a drug, or cost-sharing, tier – for example, Generic Drugs tier. The amount you pay as a copayment or coinsurance depends, in part, on which tier the drug is in. You can find more information about tiers in your *Formulary (List of Covered Drugs)*.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain or a medical condition that is quickly getting worse.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your eligibility record and any other attachments, riders or other optional coverage selected, which explains your coverage, what we must do, your rights and what you have to do as a member of this plan.

Exception – A type of coverage determination allowing you to request that a plan restriction or limit be waived for certain drugs. Examples include: allowing a different dosage or quantity of a drug, allowing you to use a drug without getting approval for it in advance or allowing you to try a drug prescribed by your doctor that would normally require you to try a different drug first.

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles and coinsurance.

Generic drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, a generic drug works the same as a brand-name drug and usually costs less.

Grievance – A type of complaint you make about us or one of our network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Initial coverage limit – The maximum limit of coverage under the Initial Coverage stage.

Initial Coverage stage – This is the stage before your total drug costs, including amounts you have paid and what your plan has paid on your behalf for the year, have reached $3,700.

Late enrollment penalty (LEP) – An amount that may be added to your monthly premium for Medicare prescription drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive Extra Help from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive Extra Help, you do not pay an LEP.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most healthcare costs are covered if you qualify for both Medicare and Medicaid. See the **Appendix** for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration (FDA) or supported by certain reference books. See **Chapter 3, Section 3** for more information about a medically accepted indication.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities and people with End-Stage Renal Disease, also called ESRD (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) Plan or a Medicare Medical Savings Account (MSA) Plan. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and are not paid for under Original Medicare. In many cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage (MA-PD).** Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with ESRD (unless certain exceptions apply).

Medicare Annual Enrollment Period – A set time each fall when members can change their health or drug plans or switch to Original Medicare. The Medicare Annual Enrollment Period is from October 15 until December 7 every year.

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a health maintenance organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand-name drugs to Part D enrollees who have reached the Coverage Gap stage or total drug spend of $3,700 and who are not already receiving Extra Help. Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand-name drugs are discounted.

Medicare health plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs and Programs of All-Inclusive Care for the Elderly (PACE).

Medicare prescription drug coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (member of this plan, or plan member) – A person with Medicare who is eligible to get covered services, who has enrolled in this plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network pharmacy – A network pharmacy is a pharmacy where members of this plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with this plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Original Medicare ("Traditional Medicare" or "Fee-for-Service" Medicare) – Original Medicare is offered by the Federal government and is not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals and other healthcare providers payment amounts established by Congress. You can see any doctor, hospital or other healthcare provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount and you pay your share. Original Medicare has two parts — Part A (Hospital Insurance) and Part B (Medical Insurance) — and is available everywhere in the United States.

Out-of-network pharmacy – A pharmacy that doesn't have a contract with this plan to coordinate or provide covered drugs to members of this plan. As explained in this *Evidence of Coverage,* most drugs you get from out-of-network pharmacies are not covered by this plan unless certain conditions apply.

Out-of-pocket costs – See the definition for "cost-sharing" at the beginning of this chapter. A member's cost-sharing requirement to pay for a portion of drugs received is also referred to as the member's out-of-pocket cost requirement. Your out-of-pocket costs are what move you toward the Catastrophic Coverage stage.

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D drugs – Drugs that can be covered under Part D. Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs. Please refer to your 2017 *Formulary (List of Covered Drugs)* or **Chapter 3** for more information on what drugs are covered by this plan.

Part D Income-Related Monthly Adjustment Amount (Part D–IRMAA) – If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium. For example, individuals with income greater than $85,000 and married couples with income greater than $170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the Part D income-related monthly adjustment amount. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Premium – The periodic payment to Medicare, an insurance company or a healthcare plan for health or prescription drug coverage.

Prior authorization – A type of plan restriction requiring approval in advance to get certain drugs that may or may not be on our formulary. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – A group of practicing doctors and other healthcare experts paid by the Federal government to check and improve the care given to Medicare patients. See the **Appendix** for information about how to contact the QIO in your state.

Quantity limits – A type of plan restriction on certain drugs that is designed to limit the use of selected drugs for quality, safety or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Service Area – A geographic area where a prescription drug plan accepts members if it limits membership based on where people live. The plan may permanently disenroll you if you move out of the plan's service area.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the plan's service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home or if we violate our contract with you.

Step Therapy – A type of plan restriction on certain drugs that requires you to first try another drug to treat your medical condition before we will cover the drug your doctor may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind or age 65 and older. SSI benefits are not the same as Social Security benefits.

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